APPLICATION FOR CERTIFICATION OR LICENSURE

State Form 48161 (R3 / 7-06) / CM 0001

Indiana Family and Social Services Administration
Division of Mental Health and Addiction
Certification and Licensure
402 West Washington Street, Room W353
Indianapolis, IN 46204-2739

INSTRUCTIONS:
1) Complete original application and attachments.
2) .Forward to address in upper right corner of form.

I. GENERAL INFORMATION

Information about the applicant agency is requested in this section. Information about ownership is required as stated in the attachments.

Legal name of applicant agency	
DBA name of agency, if different	
Employer Federal ID#	Organization Structure of Applicant Agency. *(Check One:)* ☐ **Governmental Entity** ☐ **Private Nonprofit** ☐ **Private for Profit**
Chief Executive Officer **1. Applicant Agency:**	**2. Community Mental Health Center (if different person)** :
Main business office location address and telephone number of applicant agency *(Number and Street. Note: A post office box number is not considered a location.)*	
City, State, ZIP code, **and** County	
Telephone Number, Fax Number, **and** E-mail or Internet Address	
Mailing address of applicant agency, if different from location address Street or Post Office Box Number, City, State, and ZIP	

II. CERTIFICATION/LICENSURE

Check all boxes that apply within one category and indicate whether this is an application for a new certification/license or a request for renewal.

TYPE OF CERTIFICATION OR LICENSE	RULE	RENEW	NEW
SERVICE PROVIDER APPLICATION:			
Community Mental Health Center (CMHC)	440 IAC 4.1		
Private Mental Health Institution/Inpatient (PIP)	440 IAC 1.5		
Addiction Services Provider (AS)	440 IAC 4.4		
Residential Care Provider (RCP) [1]	440 IAC 6		
Subacute Stabilization Facility	440 IAC 7.5		
Supervised Group Living Facility	440 IAC 7.5		
MANAGED CARE PROVIDER (MCP) APPLICATION: Indicate population below.			
MCP – SMI (Seriously Mentally Ill)	440 IAC 4.3		
MCP – SED (Seriously Emotionally Disturbed Children)	440 IAC 4.3		
MCP – CA (Chronically Addicted)	440 IAC 4.3		
MCP -- GAM (Compulsive Gambling Addiction)	440 IAC 4.3		

[1] Community Mental Health Centers and Managed Care Providers are deemed Residential Care Providers.

III. RESIDENTIAL SETTINGS - 440 IAC 7.5

Indicate residential settings which are operated by the applicant agency.

Setting	Number of Facilities	Total Number of Beds
Supervised Group Living Facility (SGL)		
Subacute Stabilization Facility		
Transitional Residential Facility (TRS)		
Alternative Family for Adults Program (AFA)		
Semi-Independent Living Program (SILP)		

IV. ACCREDITATION

List all accrediting agencies applicable to requested licensure/certification. A copy of the **complete** accreditation report must be included before the application will be processed.

Accrediting Agency	Date of Survey	Effective Dates of Accreditation	Status of Accreditation[1]	Program Standards or Manual[2]
		From: To:		
		From: To:		

[1] Status of Accreditation: Indicate type of accreditation received, whether corrections are needed, and follow-up time.
[2] Indicate inpatient, outpatient, residential (non-inpatient), addiction treatment etc.

Has the applicant agency applied for accreditation and been denied accreditation by an accrediting agency in the last 24 months?

☐ **YES** ☐ **NO**

If YES, give accrediting agency name and date of decision.

V. ATTACHMENTS

Submit the required attachments required for each certification/license. Label all documents to correspond to the Attachment List. **All applicants except Managed Care Provider applicants must complete a Facility Facts Record for each location operated by the applicant agency. Managed Care Providers must complete a Chart of Provider Panel Members.**

VI. GENERAL CONDITIONS

Upon certification/licensure for the requested service(s) and/or setting(s), the applicant agrees to abide by all laws, rules and administrative directives governing the certified/licensed service(s). **THE APPLICANT AGREES TO GIVE THE REQUIRED WRITTEN NOTICE OF CHANGES TO THE DIVISION OF MENTAL HEALTH AND ADDICTION**. The Division of Mental Health and Addiction may require a new application as a result of such changes. The applicant affirms that the statements and declarations contained herein are true and correct to the best of the applicant's knowledge.

Applicant Agency	
Signature (Individual with signature authority)	Date *(month, day, year)*
Type or print the name of the signatory	Official Title

RETURN THIS APPLICATION FORM AND ALL REQUIRED ATTACHMENTS TO ADDRESS ON FACE OF FORM